Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HealthTrust, LLC

Respondent Name
Pennsylvania Manufacturers Association

MFDR Tracking Number
M4-15-0761-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
October 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HealthTrust has submitted these claims multiple time now and each time an incorrect payment amount is generated or no payment at all is remitted. The last submission was on August 28, 204, and there has been no response from the carrier regarding either a denial or an additional payment.

The claims are attached, along with the medical documentation showing the daily notes and the time allowed in each daily session along with the check copies where partial payments were made. On October 23, 2014, I personally stayed on hold for 1 hour and 50 minutes waiting to talk to the audit company to see if these claims had been processed since the August submission. I started with 10 people being in a position ahead of my call. After 1 hour, 1 was moved down to 1 caller ahead of me and so I waited for another 55 minutes. At approximately 5 minutes after 5:00 pm a computer generated voice came on the phone and indicated that the system was experiencing technical problems and the call was DROPPED. At 5:00, after 1 hour and 55 minutes of waiting, the call was dropped. This was after leaving 3 messages for the adjustor to call me also with no response.

Please review the documentation and have the carrier reimburse HealthTrust for the balance due on each of the dates of service shown."

Amount in Dispute: $1850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are writing to provide a response / position statement to Healthtrust's Medical Fee Dispute Resolution Request requesting payment of an additional $1,850.00 for services rendered on March 24, 25, 26, and 27, 2014.

March 24, 2014 DOS

Respondent maintains its denial of Healthquest's request for an additional $300.00 for the March 24, 2014 date of service. Respondent previously issued payment to Healthtrust in the amount of $655.00, $5.00 over the full amount in dispute. Payment in the amount of $125.00 was issued on May 22, 2014 (Check No. 0109095027); payment in the amount of $525.00 was issued on May 14, 2014 (Check No. 0111200745); and payment in the amount of $105.00 was issued on November 12, 2014 (Check No. 0113982775). Please see the attached Explanation of Benefits.

March 25, 2024 DOS

Carrier initially issued payment in the amount of $125.00 for the March 24, 2014 date of service (Check No. 0109095028. On reconsideration in July 2014, Genex determined that an additional $225.00 was due, and the additional payment was subsequently issued on August 2, 2014 (Check No. 0111547875). Genex has subsequently audited the bill again and determined that an additional payment of $400.00 is due, bringing the total amount of payment to $750.00, the full amount requested by the provider. Payment in this amount was

issued to Healthtrust on November 19, 2014 (Check No. 0114173568). Please see the attached November 17, 2014 Explanation of Benefits.

March 26, 2014 DOS

Carrier initially issued payment in the amount of $125.00 (Check No. 0109095025). Genex has subsequently audited the bill again and determined that an additional payment of $625.00 (the full amount in dispute) is due for the March 26, 2014 date of service. Payment in this amount is being issued to Healthtrust as reflected in the attached November 17, 2014 Explanation of Benefits.

March 27, 2014 DOS

Carrier initially issued payment in the amount of $100.00 (Check No. 0109095026). On reconsideration in July 2014, Genex determined that an additional $250.00 was due, and the additional payment was subsequently issued in August 2014 (Check No. 0111547876). Genex has subsequently audited the bill again and determined that an additional allowance of $300.00 (the total amount in dispute is warranted for the March 27, 2014 date of service. Payment in this amount is being issued to Health trust as reflected in the attached November 17, 2014 Explanation of Benefits."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24 – 27, 2014	Chronic Pain Management (97799-CP)	$1850.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   For date of service 3/24/14:
   - 320 – Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
   - W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - B12 – Re-evaluated; additional payment is recommended.
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - B13 – Re-evaluated; no additional payment is recommended.
   - Note: These charges were re-evaluated & we will stand by our original review. No additional recommendation was made based on the submitted information. Payment for a total of $650.00 was received under bill CZTX-3156 & 4047.

   For date of service 3/25/14:
   - 320 – Non- accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
   - W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - B12 – Re- evaluated; additional payment is recommended.
   - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - Note: This is in reference to your appeal on the attached claim. Your appeal has been addressed and we have determined that an additional allowance is warranted. Please note that additional payment has been received under bill CZTX-3155 & CZTX-3908 for a total of $350.00.

   For date of service 3/26/14:
   - 320 – Non- accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
   - W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.

- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- B12 – Re- evaluated; additional payment is recommended.
- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- Note: This is in reference to your appeal on the attached claim. Your appeal has been addressed and we have determined that an additional allowance is warranted.

For date of service 3/27/14:

- 320 – Non- accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
- W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- B12 – Re- evaluated; additional payment is recommended.
- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
  Note: This is in reference to your appeal on the attached claim. Your appeal has been addressed and we have determined that an additional allowance is warranted.

Issues

1. What is the allowable amount for the disputed services?
2. What is the total paid by the insurance carrier for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (h) states, in relevant part,

   > The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of … Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs … To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual… (1) Accreditation by the CARF is recommended, but not required... (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR… (5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

   Review of the submitted documentation supports that the disputed charges are for a Chronic Pain Management program. A search of CARF International finds that the requestor is not a CARF accredited provider. Therefore, reimbursement is calculated at 80% of the total MAR.

   Documentation for date of service March 24, 2014 supports 6.5 hours. Therefore, the MAR for this date of service is $812.50. 80% of the MAR is $650.00. This is the total allowable for this date of service.

   Documentation for date of service March 25, 2014 supports 7.5 hours. Therefore, the MAR for this date of service is $937.50. 80% of the MAR is $750.00. This is the total allowable for this date of service.

   Documentation for date of service March 26, 2014 supports 7.5 hours. Therefore, the MAR for this date of service is $937.50. 80% of the MAR is $750.00. This is the total allowable for this date of service.

   Documentation for date of service March 27, 2014 supports 6.5 hours. Therefore, the MAR for this date of service is $812.50. 80% of the MAR is $650.00. This is the total allowable for this date of service.

   The total allowable for the disputed services is $2800.00.

2. A review of the Explanations of Benefits (EOBs) finds the following payments:

   For date of service March 24, 2014:
   - EOB dated April 18, 2014 - $125.00
   - EOB dated July 17, 2014 - $525.00
   - Total payment - $650. 00

   For date of service March 25, 2014:
   - EOB dated April 18, 2014 - $125.00
   - EOB dated July 30, 2014 - $225.00
   - EOB dated November 17, 2014 - $400.00

- Total payment - $750.00

For date of service March 26, 2014:

- EOB dated April 18, 2014 - $125.00
- EOB dated November 17, 2014 - $625.00
- Total payment - $750.00

For date of service March 27, 2014:

- EOB dated April 18, 2014 - $100.00
- EOB dated July 30, 2014 - $250.00
- EOB dated November 17, 2014 - $300.00
- Total payment - $650.00

The total of payments from insurance carrier for the disputed services is $2800.00.

3. The total allowable for the disputed services is $2800.00. The insurance carrier paid $2800.00. Therefore, no additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	April 28, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.